

Sustaining Integrated Services Report - Lessons Learned from PBHCI Alumni

Like any organization using grant funds for critical services, SAMHSA Primary and Behavioral Health Care Integration (PBHCI) grantees start planning to sustain services early in the grant process to ensure longevity of services. The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) – the technical assistance center for the PBHCI program – provides assistance during the sustainability planning process to support grantees in achieving successful outcomes.

CIHS has received numerous inquiries about how former PBHCI grantees sustained services. The questions are a variation of “How did grantees plan for and how have they sustained, primary care, care coordination, wellness services and peer support?” To respond to this need, CIHS interviewed and surveyed 19 alumni about their ability to sustain primary care, care coordination, wellness services and peer support after the grant. The following are the themes that emerged during the alumni engagement about lessons learned in sustaining PBHCI. Grantee alumni and CIHS recommend using the [PBHCI Sustainability Checklist](#) and other resources while planning your sustainability activities.

“If the grant expires before you have a plan, you will lose consumers and lose demand. It is much harder to rebuild without the benefit of grant funding.”

-Cohort 3 Project Director

Number of grantees in each award year

| Cohort I | Cohort II | Cohort III | Cohort IV | Cohort V | Cohort VI | Cohort VII |
|-------------|------------|-------------|------------|-------------|------------|-------------|
| 2009 | 2010 | 2010 | 2011 | 2012 | 2013 | 2014 |
| 13 grantees | 9 grantees | 34 grantees | 8 grantees | 29 grantees | 7 grantees | 26 grantees |

Primary Care

Primary care providers are not only responsible for providing direct care to consumers; they are seen as leaders who shape the system of care. **Fifteen of the 19 organizations (79 percent) were able to maintain some level of primary care.** Among those who partnered with a federally qualified health center (FQHC) during the grant period, 67 percent continued the partnership post-grant; the remainder decided to build in-house capacity. Those who continued the partnership were able to do so because of a shared mission and financial goals. Those who developed in-house capacity experienced challenges related to optimizing staffing, generating enough revenue to sustain the service and ensuring there was not a gap between the end of the primary care partnership and the development of in-house capacity.

Lessons Learned

I'm glad we...

- Reassessed our staffing model. We found that the majority of our consumers' needs were met by our nurse practitioner, which lessened the demand on our primary care physician.
- Shortened physician visits by training other staff to address routine health questions. Case-to-care training gave behavioral health staff the ability to address simple health questions.
- Collected payment information (i.e., Medicare, Medicaid, private insurance, no insurance) for everyone we served during our first year. This gave us a better picture of our expected post-grant revenue.

I wish we....

- Looked into becoming an FQHC after the second year of the grant. This would have given us two years to get the service up and running before the grant ended.
- Determined the break-even point for primary care services during the grant and done more to ensure we saw that many patients each day.
- Discussed the long-term sustainability of primary care services with our FQHC partner in the first two years of the grant.

"We had partnered with an FQHC all along and at the end of it, decided to go on our own...because we weren't really integrated. They did things their way. If I could have done this over again, two years into the grant I would have taken it over ourselves, then we would have had the grant supporting us while we were learning all the things we are learning now."

- Cohort 3 Project Director

Resources

- [Integrated Practice Assessment Tool](#) (IPAT)
- The [Business Case for Integration of Behavioral Health and Primary Care](#)
- The [Core Competencies for Integrated Care](#)

Care Coordination

The PBHCI request for application describes care coordination as the implementation of the individualized treatment plan through appropriate linkages, referrals, coordination and follow-up to needed services and supports. Alumni who were able to maintain care coordination utilized a wide array of funding mechanisms, including demonstration projects with their state and/or managed care organizations (4), local hospital systems (1), HRSA integration grants (1) and other local funding (2). To obtain this funding, many assembled a "roadshow" containing cost saving and health improvement data from their integration program, national integration statistics and any other information that would demonstrate a benefit to the potential funder. The project leads took the roadshow to all relevant stakeholders. In many cases, it was a slow process from first contact to demonstration project.

"By the end of the program, we had morphed into a care coordination program. We had a nurse and outreach worker and [we are] a link between the primary care program and all other care programs that the clients were in."

Cohort 1 Project Director

Lessons Learned

I'm glad we...

- Participated in state-level integration workgroups. Ultimately, they led to demonstration projects with the state and managed care organizations.
- Brought data to each conversation with stakeholders. Even if it was rudimentary data, we were able to enhance our data through creating partnerships.
- Worked with other providers to develop case rates for care coordination demonstrations with managed care.

I wish we....

- Pursued alternate funding during the grant. We lost our nurse care managers as soon as the grant ended.
- Collected data about reducing the use of more expensive services to support the cost savings of care coordination.
- Were more proactive in billing for care coordination.

Resources

- AHRQ's [Care Coordination Measures Atlas](#)
- National Quality Forum's [Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination](#)
- CIHS' [Care Coordination Innovation Community](#) webinar series

Wellness Promotion

SAMHSA defines wellness as an individual's mental, emotional, physical, occupational, intellectual and spiritual well-being. Early PBHCI grantees were allowed flexibility in delivering wellness promotion services, which included anything from healthy eating classes to tobacco-free campus policies.

"The model that we developed from the PBHCI grant that has been sustainable is our health coaching service that we offer. We were able to train 25 health coaches across the state. We are able to bill for health coaching and case management."

—Cohort 3 Project Director

Seventeen of the 19 organizations (89 percent)

reported that they are still providing at least some wellness services. The most common wellness groups provided post-grant are tobacco cessation, chronic disease self-management (e.g., Stanford Diabetes Self-Management) and exercise groups. Multiple organizations reported a reduction in wellness groups due to lack of alternative funding streams. In addition to wellness groups, organizations made changes to one-on-one wellness promotion. These organizations work to make sure all staff, not just designated wellness staff, promote physical health in case management, therapy, psychiatry and other billable behavioral health visits.

Lessons Learned

I'm glad we...

- Created a three-day wellness training program for all behavioral health staff so we could promote wellness in all interactions.
- Continued tracking health indicators even though we no longer provide primary care. Tracking health outcomes allowed us to monitor the success of our wellness programs, which allowed us to make a case for maintaining wellness programming.
- Analyzed cost savings associated with health coaching.

I wish we...

- Built a registry outside of our electronic health records (EHR) as quickly as possible to track health improvement. This would have helped build a case for our wellness services.
- Hired billable staff to lead our wellness groups. We were unable to sustain our wellness staff after the grant.
- Worked to create a culture of wellness with all staff at the beginning of the grant.

Resources

- [Case Management to Care Management Training](#)
- CIHS' [Wellness Strategies](#) webpage
- [Culture of Wellness Organizational Self-Assessment](#)
- [What Works In Changing Health Behaviors](#) webinar

Peer Support

Peer support is provided by a person with hands-on serious mental health issues (SMI) experience who works with consumers to activate self-management. **Fifteen of the 19 organizations (79 percent) reported using peer support services in various capacities.** Those who reported a smooth transition were able to bill for peer support, integrate peer support specialists into integration teams and provide proper training and supervision. Organizations that struggled had no experience employing peers, did not clearly define the roles and failed to fill peer support positions.

Lessons Learned

I'm glad we...

- Trained staff about the importance of peer participation in team-based care. This helped to integrated peers into care teams.
- Pursued training for peer staff to enable them to lead wellness classes.

"I don't think people recognize the value of peers yet in the way that the will, ultimately."

—Cohort 3 Project Director

I wish we...

- Gave peers more meaningful work. Some reported feeling like chauffeurs instead of members of the integration team.
- Provided more supervision and training to our peer support staff.

Resources

- [Whole Health Action Management](#) (WHAM) Training
- [Peer-to-Peer Health and Wellness Programming Matrix](#) (Draft)
- CIHS' [Peer Providers Webpage](#) includes information on billing for peer services, roles of peers and sample job descriptions
- [Pillars of Peer Support Services: Peer Specialist Supervision](#)

Conclusion

In addition to lessons learned, the alumni interviews showcased the dedication of PBHCI staff to continue providing integrated care. Their perseverance and lessons learned are valuable to:

- SAMHSA – to inform future grant programming
- CIHS – to inform future technical assistance
- Current and future PBHCI grantees – to inform experience based on lessons from their predecessors

Each grantee expressed a willingness to maintain contact with SAMHSA, CIHS and PBHCI grantees in some capacity. Many have attended regional meetings, webinars and affinity group calls to stay connected and lend their wisdom to the conversations. Their continued guidance will ensure that current and future PBHCI grantees have a more direct path to sustainability.